

LAST NAME	FIRST	MIDDLE	AGE	DATE OF BIRTH	SEX	SOCIAL SECURITY #
PATIENT'S ADDRESS	STREET	APT#	CITY	STATE	ZIP	HOME PHONE
MARITAL STATUS M S D W UNDER AGE 18	PATIENT'S/GUARDIAN'S EMPLOYER				OCCUPATION	
WORK ADDRESS	STREET	CITY	STATE	ZIP	WORK PHONE	OK TO CALL WORK YES NO
PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME) NAME			RELATIONSHIP	WORK#	HOME#	
E-MAIL ADDRESS			WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?			

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE YES NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS			
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN		
GROUP/PROGRAM NUMBER	EMPLOYMENT (IF DIFFERENT THAN ABOVE)		EMPLOYER ADDRESS		
SECONDARY COVERAGE YES NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS			
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN		
GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT THAN ABOVE)		EMPLOYER ADDRESS		

ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to e by this dental office, I am obligated to pay said office in accordance with credit terms and policy.

I consent to the making of videotapes photographers, and x-rays before, during and after treatment, and the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and so realize the risks and limitations involved.

Signature _____ Date _____